EFFECTIVE

November 1, 2010.

Subject

Long Term Care (LTC).

1. Glossary.
2. BEM 164, Extended-Care.
3. BEM 546, Post-eligibility Patient-pay Amounts.

An LTC applicant's patient pay amount may be adjusted by the Department of Community Health (DCH) to allow the applicant to pay some types of medical expenses incurred before application for Medicaid.

1) GLOSSARY

Indicated or Demonstrated a Disability

Information in the recipient's current Medicaid eligibility case file shows the recipient has alleged a serious mental or physical impairment or injury. A condition, impairment, or injury will not be considered serious if information in the case file shows it is so minor it cannot reasonably be expected to interfere with the individual's mental or physical functioning, or cannot reasonably be expected to last more than a year, or to result in death.

Following a disability review an individual who has indicated or demonstrated a disability may or may not be determined to meet the definition of disability used to determine eligibility for Medicaid under SSI related disability based Medicaid types of assistance (TOA).

PPA

Patient-Pay Amount.

Pre-Eligibility Medical Expense

Unpaid medical expenses incurred in the three months prior to application for Medicaid. The offset is only allowed if used to pay the provider(s) for the medical expense and will be terminated if the

recipient fails to pay the provider. In general the allowable expenses are the same as allowed for a group 2 deductible case. In addition, the medical expense(s) must be:

- Unpaid, and an obligation still exists to pay.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.
- Can include cost of room and board for Medicaid long term care (LTC) facilities, remedial care and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- Must be reported prior to the first Medicaid redetermination following the initial eligibility.
- DCH will terminate offsets if there is a failure to pay the medical provider with the funds.

L/H Patient

The MA client who was in the hospital and/or LTC facility in an long term care facility or hospital (L/H) month. Mr. Jones in the examples below is the L/H patient.

L/H Month

- A calendar month containing:
- At least one day that is part of a period in which a person was (or is expected to be) in an LTC facility and/or hospital for at least 30 consecutive days, and
- No day that the person was a waiver patient.

Example: 1

Mr. Jones is admitted to an LTC facility on October 5th and is discharged December 1st.

October, November and December are L/H months.

Example: 2

Mr. Jones is admitted to a hospital October 31st, transferred to an LTC facility in November and discharged from the LTC facility December 15th.

October, November and December are L/H months.

Example: 3

Mr. Jones is admitted to a hospital October 28th and discharged December 11th. He is approved for the waiver effective December 17th.

October and November are L/H months. Reminder: The Patient Pay Amount (PPA) is not reduced or removed in the month the person leaves the facility.

2) BEM 164

Extended-Care

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

Consider eligibility under this category only if eligibility does **not** exist under BEM 154 through 163. Use this category before using a Group 2 category.

Consider Medicare Savings Program eligibility in addition to this category; see BEM 165.

This category is available only to L/H and waiver clients who are aged (65 or older), blind or disabled. See Bridges Glossary for the definition of L/H patients. See BEM 106 for the definition of waiver clients. Gross income **cannot** exceed $2022.

All eligibility factors in this item must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

NONFINANCIAL ELIGIBILITY FACTORS

- The person must **not** be eligible for MA under BEM 154 through 163 but may be eligible for a Medicare Savings Program under BEM 165.
- The person must be an L/H or waiver client.
- The person must be aged, blind or disabled; see BEM 240, Age, or BEM 260, MA Disability/Blindness. The MA eligibility factors in the following items must be met:
  - BEM 220, Residence.
  - BEM 221, Identity.
  - BEM 223, Social Security Numbers.
  - BEM 225, Citizenship/Alien Status.
  - BEM 255, Child Support.
  - BEM 256, Spousal/Parental Support.
  - BEM 257, Third Party Resource Liability.
  - BEM 265, Institutional Status.
  - BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related MA groups in BEM 211.

Assets

Countable assets **cannot** exceed the asset limit in BEM 400. Countable assets are determined based on MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies.

Income Eligibility

Income eligibility exists when **gross** income does **not** exceed:

- $1911 for months in calendar year 2008.

- $2022 for months in calendar year 2009.

Apply the MA policies in BEM 500 and 530 to determine gross income. Do not apply the deductions in BEM 540 and 541.

Income eligibility **cannot** be established with a patient-pay amount or by meeting a deductible.

Third Party Liability

Complete MSA-1354 for clients with other insurance, including long term care/nursing home insurance, and submit with a copy of insurance card if available.

Patient Pay Offsets

If an LTC applicant requests an offset of their patient pay to cover old medical bills, see Pre-Eligibility Medical Expense (PEME) in glossary and in this item. Assist the applicant by forwarding their unpaid bills to:

Medical Services Administration
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-9634
Attn: PEME

DCH will determine whether an offset is allowable.

Offsets will be applied to the months following an approval. In general, the allowable expenses are the same as allowed for a group 2 deductible case. In addition, the medical expense(s) must be:

- Unpaid, and an obligation still exists to pay.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.

- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- Must be reported prior to the first Medicaid redetermination following the initial eligibility.
- DCH will terminate offsets if there is a failure to pay the medical provider with the funds.

Verification Requirements

Verification requirements for all eligibility factors are in the appropriate manual items.

3) BEM 546

Post-eligibility Patient-pay Amounts

DEPARTMENT POLICY

MA Only

Use this item to determine post-eligibility patient-pay amounts. A post-eligibility patient-pay amount is the L/H patient's share of their cost of LTC or hospital services. First, determine Medicaid eligibility. Then, determine the post-eligibility patient-pay amount when Medicaid eligibility exists for L/H patients eligible under:

- A Healthy Kids category.
- A FIP-related Group 2 category.
- An SSI-related Group 1 or 2 category ***except:***
  - QDWI.
  - Only Medicare Savings Program (with **no** other MA coverage).

MA income eligibility and post-eligibility PPA determinations are **not** the same. Countable income and deductions from income often differ. Medical expenses, such as the cost of LTC, are never used to determine a post-eligibility PPA. Do **not** recalculate a PPA for the month of death.

PATIENT-PAY AMOUNT

The post-eligibility PPA is total income minus total need.

Total income is the client's countable unearned income plus his remaining earned income; see Countable Income in this item.

Total need is the sum of the following when allowed by later sections of this item:

- Patient allowance.
- Community spouse income allowance.
- Family allowance.
- Children's allowance.
- Health insurance premiums.
- Guardianship/conservator expenses.

COUNTABLE INCOME

For all persons in this item, determine countable income as follows:

- RSDI, Railroad Retirement and U.S. Civil Service and Federal Employee Retirement System.

- Non-SSI income for SSI recipients

Use countable income per BEM 500 and 530. Deduct Medicare premiums actually withheld by:

- Including the L/H patient's premium along with other health insurance premiums, and

- Subtracting the premium for others (example, the community spouse) from their unearned income.

Exception: Do **not** use the following special exclusion policies regarding RSDI. These policies only apply to eligibility, **not** post-eligibility patient-pay amounts.

- BEM 155, 503 COUNTABLE RSDI.
- BEM 156, COUNTABLE RSDI.
- BEM 157, COUNTABLE RSDI.
- BEM 158, COUNTABLE RSDI.

Note: The checks of clients on buy-in increase about three months after buy-in is initiated. Recompute the PPA when the

client's check actually changes. BAM 810 has information about buy-in.

- **Earned and Other Unearned Income.**

  Use BEM 500 and 530. For clients, use FIP- or SSI-related policy as appropriate. Use SSI-related policies for all other persons.

  For the **client only**, disregard $65 + 1/2 of his countable earned income. Use RFT 295 to determine the disregard. Earned income minus the disregard is **remaining earned income**.

PATIENT ALLOWANCE

The patient allowance for clients who are in, or are expected to be in, LTC and/or a hospital the entire L/H month is:

- $60 if the month being tested is November 1999 or later.
- $30 if the month being tested is before November 1999.

Exception: Use $90 for any month a patient's VA pension is reduced to $90 per month.

Use the appropriate protected income level for one from RFT 240 for clients who enter LTC and/or a hospital but are not expected to remain the entire L/H month. Reminder: The PPA is not reduced or eliminated in the month the person leaves the facility.

COMMUNITY SPOUSE INCOME ALLOWANCE

L/H patients can divert income to meet the needs of their community spouse. The **community spouse income allowance** is the maximum amount they can divert. However, L/H patients can choose to contribute less. Divert the **lower** of:

- The community spouse income allowance.
- The L/H patient's intended contribution; see Intent to Contribute in this item.

Compute the community spouse income allowance using steps one through five below.

1. Shelter Expenses

Allow shelter expenses for the couple's principal residence as long as the obligation to pay them exists in either the L/H patient's or community spouse's name.

Include expenses for that residence even when the community spouse is away (for example, in an adult foster care home). An adult foster care home or home for the aged is **not** considered a principal residence.

Shelter expenses are the total of the following monthly costs:

- Land contract or mortgage payment, including principal and interest.
- Home equity line of credit or second mortgage.
- Rent.
- Property taxes.
- Assessments.
- Homeowner's insurance.
- Renter's insurance.
- Maintenance charge for condominium or cooperative.

Also add the appropriate heat and utility allowance if there is an obligation to pay for heat and/or utilities. The heat and utility allowance for a month is:

- $529 starting January 2008.
- $550 starting January 2009.

Convert all expenses to a monthly amount for budgeting purposes.

2. Excess shelter allowance.

Subtract the appropriate shelter standard from the shelter expenses determined in step one. The shelter standard for a month is:

- $525 starting January, 2008.
- $547 starting July, 2009.

The result is the **excess shelter allowance**.

3. Total allowance.

Add the excess shelter allowance to the appropriate basic allowance. The basic allowance for a month is:

- $1750 starting April 2008.
- $1822 starting July 2009.

The result, up to the appropriate maximum, is the **total allowance**. The maximum allowance for a month is:

- $2610 starting January 2008.
- $2739 starting January 2009.

Exception: In hearings, administrative law judges can **increase** the total allowance to divert more income to an L/H patient's community spouse; see BAM 600.

4. Countable income.

Determine the community spouse's countable income; see COUNTABLE INCOME in BEM 546.

5. Community spouse income allowance.

Subtract the community spouse's countable income from the total allowance. The result is the **community spouse income allowance**.

Exception: Use court-ordered support as the community spouse income allowance if:

- The L/H patient was ordered by the court to pay support to the community spouse, **and**
- The court-ordered amount is **greater** than the result of step five.

Intent to Contribute

DHS-4592, Intent to Contribute Income:

- Determines the amount of income an L/H patient intends to contribute to his community spouse

- Instructs the L/H patient to report how much income he intends to make available
- Should be returned within 10 days

If the DHS-4592 is **not** returned within 10 days:

- Do **not** delay case actions, and
- Budget the entire community spouse income allowance.

Budget the entire allowance **until** the DHS-4592 is returned indicating the L/H patient intends to contribute **less**.

When the DHS-4592 indicating an intent to contribute **less** income is received:

- **Decrease** the income diverted to the community spouse to the indicated amount.
- Do **not increase** the income diverted to the community spouse without a new DHS-4592.
- **Decrease** the income diverted if:
  - The community spouse's circumstances change, **and**
  - The change reduces the community spouse income allowance **below** the amount indicated on the DHS-4592.
- Use timely negative action procedures to increase the patient-pay amount.

Do **not** use amounts from previous DHS-4592s when diverting income again after stopping a diversion for one of these reasons:

- An L/H patient is discharged to a non-L/H setting for 30 or more days.
- An L/H patient's ongoing MA case (including active deductible) terminates.
- An L/H patient's spouse is hospitalized or in LTC for 30 or more consecutive days.

Start the diversion process from the beginning.

FAMILY ALLOWANCE

An L/H patient's income is diverted to meet the needs of certain family members. The amount diverted is called the **family allowance**.

Family members must**:**

Live with the community spouse, **and** be **either** spouse's:

- Married and unmarried children under age 21.
- Married and unmarried children age 21 and over if they are claimed as dependents on either spouse's federal tax return.
- Siblings and parents if they are claimed as dependents on either spouse's federal tax return.

The **basic allowance** for each dependent is the monthly amount **minus** the dependent's countable income, divided by 3. The monthly amount is:

- $1750 starting April, 2008.
- $1822 starting July, 2009.

The **family allowance** is the sum of the dependents' basic allowances.

CHILDREN'S ALLOWANCE

L/H patients without a community spouse can divert income to their unmarried children at home who are under age 18 **and** do **not** receive FIP or SSI.

The amount diverted is called the **children's allowance**. It is the children's protected income level from RFT 240 **minus** their net income. **Net income** is 80 percent of countable earned income per RFT 295, **plus** countable unearned income.

Do **not** divert income if information concerning the children's income is **not** provided.

HEALTH INSURANCE PREMIUMS

Include as a need item the cost of any health insurance (see PRG) premiums (including vision and dental insurance) the L/H patient pays, regardless of who the coverage is for. This includes Medicare premiums that a client pays.

Example: L/H patient pays health insurance premiums for two (self and spouse). Allow health insurance premiums for two.

Do **not** include premiums paid by someone other than the L/H patient as a need item.

Convert the cost of all premiums to a monthly amount for budgeting purposes.

Note: Allow the $5 deduction paid by GM retirees which includes LTC insurance coverage as an insurance expense deduction.

GUARDIANSHIP/ CONSERVATOR EXPENSES

Allow $60 per month when an L/H patient pays for his court-appointed guardian and/or conservator. Guardianship/conservator expenses must be verified and include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

DHS-3227, TENTATIVE PATIENT-PAY AMOUNT NOTICE

Send a DHS-3227, Tentative Patient-Pay Amount Notice, within five working days of application when the applicant is in LTC, **and** a final determination will **not** be made within five working days from date of application.

Send the DHS-3227 to the client and the LTC facility.

NOTIFICATION

Notify both L/H patients and their community spouses **in writing** of:

- Their hearing rights, **and**
- The amount of and method for computing the:
  - Community spouse income allowance, **and**
  - Family allowance.

Provide notice when:

- First calculating community spouse income or family allowance.
- The amount of either allowance changes.
- L/H patients, their community spouses, or representatives of either spouse request it.

Use the following forms to provide notice:

- DHS-4587, Community Spouse and Family Income Allowance Notice.

- DHS-4584, Community Spouse and Family Income Allowance Record.

Send a DHS-4592, Intent to Contribute Income, when the community spouse income allowance is greater than zero.

PATIENT PAY OFFSETS

Long-term care (LTC) facilities may deduct the following from a person's PPA:

- The cost of certain medically necessary services **not** covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers, and

- The MA co-payments for covered services.

The remainder of the PPA is then applied to the cost of care provided by the LTC facility. Department of Community Health determines whether an offset is allowable.

PPAs are **not** offset by local office staff.

Note: If an LTC applicant requests an offset of the patient pay to cover old medical bills see PEME in glossary and in this item. Assist the applicant by forwarding their unpaid bills to:

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- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.
- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- Must be reported prior to the first Medicaid redetermination following the initial eligibility.
- DCH will terminate offsets if there is a failure to pay the medical provider with the funds.

VERIFICATION REQUIREMENTS

Verify income per BEM 500.

Clients must verify the following before the cost can be used to determine excess shelter:

- Shelter obligation and amount.
- Heat and utility obligation but **not** amount.

These must be verified at application, redetermination or change.

Verify the cost of health insurance premiums before allowing the expense at application, redetermination or change.

VERIFICATION SOURCES

Shelter Obligation and Amount:

- Mortgage or rental contracts.
- Statement from mortgage company, bank or landlord.
- Tax or assessment bill or a collateral contact with the appropriate government department.
- Insurance policy, receipt or bill for premium or collateral contact with the insurance company.

Heat and Utility Obligation:

- Current bill or receipt or a written statement from the heat/utility provider.
- Collateral contact with the heat/utility provider.

Health Insurance Premiums:

- Insurance policy.
- Receipt or bill for premium.
- Contact with insurer.

Guardian/Conservator Expenses:

- Court Documents.

EXHIBIT - VA
NOTICE

This is a portion of an April 1991 letter announcing reduced VA benefits. Key wording is bolded.

You have been **a patient in a Medicaid-approved nursing home and covered by a Medicaid** plan for services since (Date) . **Because you have no dependents and are receiving Improved Pension, the law requires that we limit your pension to $90.00 monthly** while you are receiving this type of care.

For that reason, we propose to reduce your benefits from (Date) . No overpayment will be created.

This $90.00 monthly payment is for your incidental needs, such as toilet articles, snacks, etc. and **no part of this payment should be used by Medicaid to cover your medical expenses.** You should notify your state Medicaid office that your Improved Pension is being reduced.

MANUAL MAINTENANCE INSTRUCTIONS